Review of Individual Long-Term Care Insurance Policies

subject to M.G.L. c. 175 and 211 CMR 65.00 et al.

Insurer _____

NAIC # _____

Name of Plan, Form # _____

Contact person, Title _____

Address _____

Telephone _____ Fax _____

Date received _____ Reviewed by _____

$75 form filing fee processed on _____ *801 CMR 4.02(21); SRB #*_____
$150 rate filing fee processed on _____ *801 CMR 4.02(30); SRB #*_____

This represents the checklist tool used by State Rating Bureau analysts to review policies according to the minimum standards identified in relevant statutes and regulations.

*Filing is not complete for purposes of *M.G.L. c. 175 §193F* until all required items have been received in the SRB.

Pursuant to Bulletin 2001-05, this checklist is required to be submitted when filing individual long-term care insurance policy form(s), whether submitted as a new form or as a revision to an existing form.

Next to each item on the checklist, indicate the page number and/or section where the noted item is described within the filed form(s) to assist the State Rating Bureau analyst in locating the section of the filing addressing the checklist item.

- **If an item is not applicable to a company filing, please note "N/A" next to the item on the checklist and explain in your letter why the item is not applicable to the filing.**
- **If an item only requires confirmation that the company complies with particular statutory or regulatory requirements, please place a checkmark next to the item certifying company compliance with the item.**

Filings that do not include a properly completed checklist will be returned and not reviewed.

Policy Forms

General Requirements

___ Filing is for a nongroup (individual) policy.
___ Each form submitted for final approval must be printed, be a printer's proof, or be in the form in which it will be issued. If more than one company uses the same forms, each company's forms must be submitted separately on its own letterhead.
___ Policy summaries must be filed with the corresponding policy forms:
- ___ Policy _____
- ___ Disclosure Statement (Outline of Coverage) _____
- ___ Application _____
- ___ Notice of Information Practices _____
- ___ Inflation Option _____
- ___ Nonforfeiture Option _____
- ___ Policy Illustration Form _____
- ___ Replacement form _____

___ The policy, riders and all amendments, as well as the application, outline of coverage and other required disclosure materials distributed to any potential applicant must be presented in no less than 12-point type as well as satisfy the readability standards of M.G.L. c. 175 § 2B. *211 CMR 65.09(2)(a)*
___ Filing includes certification by company official that each form meets standards of M.G.L. c. 175 §2B. If insurer feels that any form is exempt from M.G.L. c. 175 §2B, letter should state reason for exemption. The term "text" includes all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and schedule pages and tables used in the policy. *M.G.L. c. 175 §2B*
- ___ Text of each form achieves minimum Flesch score of 50 as stated in certification. (A statement to the effect that the score exceeds 50 is not permitted.)
- ___ a. It is printed, except for tables, in not less than ten-point type, one point leaded.
  Note: 211 CMR 65.09(2)(a) requires 12-point type (see above)
- b. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders;
- c. It contains a table of contents or an alphabetical subject index;
- d. The width of margins and ink to paper contrast do not interfere with the readability of the form; and
- e. The organization of the content of the policy and the summary of the policy are conducive to understandability of the form.

___ If a policy has a specification page, it should provide the following information:
- ___ Policy number ___ Name of insured ___ Other persons covered at issue date
- ___ Effective date ___ Listing of the premium or premiums payable and the periods to which they apply
- ___ Lists, with cost, if any, of each exclusionary waiver and of each premium-bearing rider or endorsement. Unless the insured has given a signed acceptance, the listing shall also include a brief description of each.

___ Each form must contain a form number on the lower left-hand corner of the cover page OR on the first page of the form if the form number would be visible with the cover closed. *M.G.L. c. 175, § 108 2.(a)(6)*
___ All policies and contracts must be headed by the corporate name of the company. If two or more insurers are under a common management and represent themselves to be or are customarily known as an insurance company group or similar insurance trade designation, they may, with the approval of the commissioner, head or title policies with the name of the group or similar trade designation or with the names of the individual members of the group, provided that the company assuming the insurance is specifically identified. *M.G.L. c. 175, §18*
___ All policies shall be signed by its secretary or an assistant secretary, or in their absence by a temporary secretary, and by its president or a vice-president, or in their absence by two directors. Riders or endorsements may be signed by one of the aforesaid officers of the company. A facsimile of the required signature is acceptable. *M.G.L. c. 175, §33*

Rate Filing

___ A rate filing must be enclosed with each policy, rider, or endorsement that affects the premium rate to be charged. *211 CMR 42.06(2)*

___ All rate filings shall at least explain formulas used to derive rates, expected claim costs, assumptions regarding mortality, morbidity and lapse rates, and the detailed commission schedule and anticipated administrative expenses associated with the policy. In order to substantiate rate revision filings, filings must maintain experience for that policy form, may combine experience for different policy forms where the coverage is substantially the same, and must demonstrate that the carrier is using fund accounting for guaranteed renewable policies to reflect premiums, investment income, losses, expenses, and provisions for reserves specific to that policy form.

___ Any rates filed, whether initial or revised, will be disapproved unless the aggregate anticipated loss ratio for the entire period for which rates are computed to provide coverage meets the loss ratio standard for the policy. *211 CMR 42.06(2)*

- ___ No less than 60% for policies sold as standard individual policies *211 CMR 42.06(2)(i)*
- ___ No less than 80% for policies sold as group conversion policies *211 CMR 42.06(2)(i)*

___ Every carrier must maintain on file with the Division an up-to-date rate manual for all individual accident and health policies, riders, and endorsements currently available for sale in Massachusetts, that must include: (a) name of carrier on each page, (b) table of contents or index, and (c) identification by form number of each policy or endorsement to which the rates apply. *211 CMR 42.06(4)*

___ A rate filing and/or rate manual & actuarial memorandum needs to be forwarded to actuary for review

___ All rate filings are subject to review by an actuary specified by the Commissioner whose costs will be paid by the company submitting the filing. Filing is to include certification from company's Chief Financial Officer that all actuarial costs associated with reviewing the filing will be borne by the company as part of the filing. . *211 CMR 42.06(3)(a)*

Cover Page

___ Company name, address and phone number are listed.
___ If the policy does not provide coverage for care in a nursing home, a notation of the fact must be prominently attached to the first page of the policy in not less than 18-point type or in some other manner that distinguishes it from the print otherwise appearing in the policy. *211 CMR 65.09(1)(a)*
___ The following statement must appear: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." *211 CMR 65.09(1)(b)*
___ A section in boldface type highlighted on the first page of the policy must either list all pre-existing condition exclusions or limitations or refer the individual to the section within the policy that lists all pre-existing condition exclusions or limitations. *211 CMR 65.09(1)(c)*
___ A renewability section notice must clearly identify whether the policy is noncancelable or guaranteed renewable, and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose). *211 CMR 65.09(1)(d)*
___ There must be on the face of the policy or certificate, or on a sticker attached to the first page of the long-term care policy or certificate, a notice that includes the following in substantially the same language and format: *211 CMR 65.09(1)(e)*

FEDERAL INCOME TAX EXEMPTIONS: This policy (**IS)(IS NOT**) intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy **(IS)(IS NOT)** intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read *Your Options for Financing Long-Term Care: A Massachusetts Guide* for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

***Questions re cover page**:*

Definitions

All definitions used in the policy must conform to the definitions in 211 CMR 65.102.

___ Definitions should be in alphabetical order for ease of disclosure of policy provisions and comparison with other policies.
___ All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. *211 CMR 65.09(2)(a)*
___ Compare all definitions in the policy to the regulation. All definitions used in the policy must conform to the definitions in *211 CMR 65.102*, *i.e.,* they must be substantially the same.

___ Adult day care means dementia day care or social day care.

___ Adult day health means those nursing, educational, and rehabilitative services provided by an adult day health program.

___ Adult day health program means a program approved by the Massachusetts Division of Medical Assistance or by a program meeting the requirements of the state in which the adult day health services are provided.

___ Adult foster care means personal care and other related services provided in a family-like setting that are provided by programs approved by the Massachusetts Division of Medical Assistance or that meet the requirements of the state in which services are provided.

___ Assisted living facility means a facility that has been certified as an assisted living residence by the Massachusetts Executive Office of Elder Affairs or a facility meeting the requirements of the state in which services are provided.

___ Chore care means non-medical services that are provided in the insured's home and are designed to maintain the insured's home so that it remains habitable, including at a minimum: vacuuming (including the moving of furniture), washing floors and walls, defrosting freezers, cleaning ovens, cleaning attics and basements to remove fire and health hazards, changing storm windows, performing heavy yardwork, shoveling snow, and making minor home repairs (such as replacing windows, door/window locks, handrails and safety rails, making minor repairs to stairs or floors and weatherizing the home).

___ Class means the underwriting and rating classifications originally used at the time that the policy was issued.

___ Community care benefits means those services provided to the insured in a home or community setting by a community-based service provider, including, but not limited to, personal care, home care and respite care.

___ Custodial care means non-medical services provided by a nursing home or a home health care agency.

___ Dementia day care means services provided by a dementia day care program operating in accordance with standards issued by the Executive Office of Elder Affairs, including a structured, secure environment for individuals with cognitive disabilities to maximize the individual's functional capacity, to reduce agitation, disruptive behavior, and the need for psychoactive medication, and to enhance cognitive functioning or a program meeting the requirements of the state in which the dementia care is being provided.

___ Disability means the functional or cognitive inability to engage in the regular and customary activities of daily living without human assistance as measured by Activities of Daily Living (ADLs).

___ Elimination period means the number of days of covered services that are to be paid solely by the insured before the insurance policy begins to pay benefits.

___ Guaranteed renewable means the policy feature that guarantees the insured's right to continue the in-force insurance policy by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable coverage without the agreement of the insured, but on a class basis, the carrier may revise premium rates for guaranteed renewable policies subject to the approval of the commissioner.

___ Home care means non-medical assistance with activities of daily living provided by a home care provider which are designed to maintain the insured's ability to live independently and include, but are not limited to, shopping, planning menus, preparing meals, home delivered meals, laundry, and light house cleaning and maintenance, including vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen/bathroom and changing beds.

___ Home care provider means an entity that provides home care services and meets the provider requirements set forth by the Executive Office of Elder Affairs or a program meeting the requirements of the state in which the home care services are being provided.

___ Home health care means nursing, home health aide, rehabilitative therapy, and nutrition counseling services.

___ Home health care agency means an agency certified by the Massachusetts Department of Public Health or an agency or program meeting the requirements of the state in which the home health care services are provided.

___ Hospice care means those palliative services provided by a hospice to a patient deemed to be terminally ill.

___ Hospice means an agency or program licensed by the Massachusetts Department of Public Health or an agency or program meeting the requirements of the state in which hospice services are provided.

___ Hospital means a facility licensed by the Massachusetts Department of Public Health or meeting the requirements of the state in which the facility is located.

___ Intermediate nursing care means routine nursing services with the periodic availability of skilled nursing and rehabilitative services that are provided by a nursing home, a home health care agency, or by an adult day health program.

___ Lifetime maximum benefit period means the maximum number of days of benefits, as chosen by the insured, which the carrier shall pay for covered benefits after the satisfaction of any elimination period or deductible.

___ Lifetime maximum dollar amount means the maximum dollar amount, as chosen by the insured, which the carrier shall pay for covered benefits after the satisfaction of any elimination period or deductible.

___ Medicaid means the program of medical assistance administered by the Massachusetts Division of Medical Assistance under Title XIX of the federal Social Security Act, 42 USCS §1396 *et seq*., and M.G.L. c 118E.

___ Medical necessity means:
(a) in accordance with accepted standards of medical practice for the diagnosis and treatment of a condition;
(b) delivered, when possible, in the least intensive setting required by the insured's condition; and
(c) not solely for the convenience of the insured or the insured's family or the insured's health care provider.

___ Medicare means the federal health insurance program under Title XVIII of the federal Social Security Act, 42 USCS §1395 *et seq*., as amended.

___ Mental or nervous condition means a condition as described in the standard nomenclature of the American Psychiatric Association.

___ Noncancelable means the policy feature that guarantees the insured's right to continue the in-force insurance policy at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage, and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

___ Nurse means all nurses, including, but not limited to, registered nurses (R.N.), licensed practical nurses (L.P.N.), or licensed vocational nurses (L.V.N.) meeting the appropriate licensing or registration requirements of the state in which the nurse provides services.

___ Nursing home means a facility that is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the Department of Public Health or the appropriate licensing agency of the state in which it is located.

___ Personal care means services provided by a personal care provider to assist in activities of daily living. Services provided by a personal care provider include, but are not limited to, assistance with bathing, bedpan routines, foot care, dressing, and care of dentures; shaving and grooming; assistance with eating; and assistance with ambulating and transfers.

___ Personal care provider means an entity that provides personal care services and meets the provider requirements set forth by the Executive Office of Elder Affairs or a program meeting the requirements of the state in which the personal care services are being provided.

___ Pre-existing condition means a medical condition for which an insured received diagnosis or treatment during the 24-month period prior to the effective date of coverage.

___ Respite care means services to temporarily relieve a caregiver of the daily stresses and demands of care for the insured. In addition to home care, personal care and home health care, respite care services may include but are not limited to short-term placements in adult foster care, nursing facilities or rest homes.

___ Skilled nursing care means skilled nursing, rehabilitative and other related services provided by a nursing home or home health care agency.

___ Social day care means training, counseling, and social services as defined by standards issued by the Executive Office of Elder Affairs, including assistance with walking, grooming, and eating and planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.

___ Use of the terms "usual and customary" or "reasonable and customary" or anything similar must be defined and explained in the policy and in the outline of coverage. *211 CMR 65.101*

Questions re definitions:

Benefits

These are **minimum** standards (insurers may broaden the benefit offered)

Mandatory provisions:

___ At a minimum, carriers must count each day that the insured receives any service that would be applied against the lifetime maximum benefit amount or maximum benefit period toward the satisfaction of an individual policy's elimination period. Individual policies may not require that elimination periods be satisfied within a specified period of time or that days be consecutive. *211 CMR 65.05(2)(a)2*.

___ Daily maximum benefit amounts for specific services must be clearly defined within the policy provisions. The daily maximum benefit may be limited by the carrier to the usual and customary cost of the service. If the service costs more than the maximum daily benefit and there is no law to the contrary, the insured is responsible for the amount over and above the daily maximum benefit. *211 CMR 65.05(2)(b)1*.

___ Lifetime maximum benefit periods must cover at least 730 days beyond the long-term care policy's elimination period. *211 CMR 65.05(2)(b)2.*

___ Policies must include a provision that enables the insured to use policy benefits after satisfying policy benefit triggers, elimination periods and deductibles to cover long-term care treatments or expenses not specifically identified in the policy's described benefits. The alternate care benefits must be made available subject to the agreement of the carrier, the insured and the insured's health care practitioner. *211 CMR 65.05(2)(e)*

___ Policies must include a provision that advises policyholders of protection against unintended lapse. The provision must state:

- ___ that the policyholder has the right to designate at least one person, in addition to the policyholder, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, and that the carrier will notify the insured of the right to change this written designation, no less often than once every two years. *211 CMR 65.10(1)*
- ___ that the policy may not lapse or be terminated for nonpayment of premium unless the carrier, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to 211 CMR 65.10(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of ten days after the date of mailing. *211 CMR 65.10(2)*

___ The policy must include a provision for reinstatement of coverage, in the event of lapse, if the carrier is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before expiration of the policy's grace period. Reinstatement must be available to the insured if requested within five months after termination, and must allow for the collection of past due premium, where appropriate. *211 CMR 65.10(3)*

___ The following language, or language substantially similar to the following, must appear conspicuously on the policy, as well as the outline of coverage, at the time of delivery [*Note: this does not apply if the policy is guaranteed issue.*]:

> "Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers were incorrect or untrue as of the date you signed the application, the carrier has the right to deny benefits or rescind your policy subject to the [time limit on certain defenses, incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the carrier at this address: [insert address]" *211 CMR 65.11(3)(b)*

___ All individual and group policies of long-term care insurance must adequately disclose all policy provisions. *211 CMR 65.09*

___ Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder or certificateholder. *211 CMR 65.09(2)(b); 211 CMR 42.09(2)*

Prohibitions:

___ Policies may not contain any provision that is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy, and benefits must be reasonable in relation to the premium charged. *M.G.L. c. 175, § 108 8.A*

___ No individual policy may condition long-term care benefits on the insured's prior hospitalization or prior receipt of services from any long-term care provider. *211 CMR 65.05(1)(b)*

___ No individual policy may restrict or deny benefits because the insured person is not eligible for Medicare. *211 CMR 65.05(1)(c)*

___ No individual policy may condition receipt of covered benefits on a requirement that the insured be making a "steady improvement", have "recuperative potential" or have "returned to pre-morbid condition" or words of similar import. *211 CMR 65.05(1)(d)*

___ No individual policy may condition receipt of any services, except medical services provided by licensed medical professionals, on any standard of medical necessity. Any carrier using a medical necessity standard must disclose that standard within the policy. *211 CMR 65.05(1)(e)*

___ Individual policies may not include elimination periods of greater than 365 days, whether services are received within or away from the home. *211 CMR 65.05(2)(a)1*.

___ Individual policies may not apply more than one elimination period unless the insured has received no benefits for at least 180 consecutive days. *211 CMR 65.05(2)(a)3.*

___ Policies may not include any policy benefits that are so limited in scope that they are not likely to be of any substantial economic value to the insured. *211 CMR 65.05(2)(d)*

Other requirements:

___ A carrier may establish a care management system to manage the benefits provided under the individual policy, and plan benefits may be disallowed if specific care management standards and procedures are not met. A carrier that intends to use a care management system must:

- ___ establish a needs assessment tool which measures functional ability. *211 CMR 65.05(1)(f)1.*
- ___ file with the commissioner a description of its care management policy and procedures, as well as the mechanism by which the insured may appeal a care management decision, and file any and all updates to the management policy and procedures with the commissioner prior to implementation. *211 CMR 65.05(1)(f)2.*
- ___ specify the care management procedures within the policy, as well as the way to appeal whenever benefits are disallowed for failure to meet care management standards, and notify insured about changes to care management procedures prior to implementation. *211 CMR 65.05(1)(f)3.*
- ___ disclose applicable care management standards to insureds upon request. *211 CMR 65.05(1)(f)4.*

[Note: If the policy includes a care management system that satisfies the above requirements, be sure that the approval letter includes the following language: "Please be advised that pursuant to 211 CMR 65.05(1)(f)2., [you, the carrier] must file any and all updates to the care management policies and procedures with the Division, and notify the insureds of these changes, prior to implementation."]

___ Individual policies may offer deductibles in lieu of elimination periods, but not both. *211 CMR 65.05(2)(a)4.*

___ Individual policies may include a lifetime maximum benefit amount in lieu of the lifetime maximum benefit period, provided that the lifetime maximum benefit amount may not be less than the product of 730 multiplied by the highest daily maximum benefit amount covered in the policy. *211 CMR 65.05(2)(b)3.*

___ Is the policy intended to be federally qualified? ___ yes___ no

If yes: policy must meet the standards set forth in the federal Internal Revenue Code and related federal regulations. If company has affixed the required sticker on the front page, this will suffice. *211 CMR 65.05(1)(a)2*

If no: policy may not include benefit eligibility standards that are more stringent than a requirement that the insured be unable to perform at least two Activities of Daily Living due to a loss of functional capacity or severe cognitive impairment. *211 CMR 65.05(1)(a)1*

___ Does the policy include home health care benefits? ___ yes ___ no

If yes, the following are prohibited practices:

___ requiring that the insured or claimant need care in a skilled nursing facility if home health care were not provided *211 CMR 65.05(2)(c)1.a.*

___ requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a hospital or institutional setting before home health care services are covered under the policy*211 CMR 65.05(2)(c)1.b.*

___ limiting eligible services to those services that are provided by registered nurses or licensed practical nurses *211 CMR 65.05(2)(c)1.c.*

___ requiring that the provisions of home health care services be at a level of certification or licensure greater than that required by the eligible services *211 CMR 65.05(2)(c)1.d.*

___ requiring that the insured or claimant have an acute condition before home health care services are covered *211 CMR 65.05(2)(c)1.e.*

___ limiting benefits to services provided by Medicare-certified providers *211 CMR 65.05(2)(c)1.f.*

___ limiting total home health coverage to a dollar amount less than one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time the covered home health services are being received. *211 CMR 65.05(2)(c)2. [Note: This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.]*

___ Home health care coverage may be applied to non-home health care benefits in the policy/certificate when determining maximum coverage under the terms of the policy or certificate. *211 CMR 65.05(2)(c)3.*

Mandatory Benefit Offers: Policies must include the following optional benefits *i.e., companies must offer this to insureds but the insureds may decline the coverages*:

___ Inflation Adjustment Benefit:

___ The applicant must be informed regarding the cost of this benefit. *211 CMR 65.06(1)(a)*

___ The initial option to purchase an inflation adjustment benefit must be offered to every applicant without additional underwriting. *211 CMR 65.06(1)(b)*

___ The carrier must require the applicant to specifically reject this benefit on the application if he/she chooses not to include this benefit in the individual policy. *211 CMR 65.06(1)(c)*

___ Nonforfeiture Benefit:

___ The applicant must be informed regarding the cost of this benefit. *211 CMR 65.06(2)(a)*

___ The initial option to purchase a nonforfeiture benefit must be offered to every applicant without additional underwriting. *211 CMR 65.06(2)(b)*

___ The carrier must require the applicant to specifically reject this benefit on the application if he/she chooses not to include this benefit in the individual policy. *211 CMR 65.06(2)(c)*

___ Home Health Care Benefit:

___ A carrier must make available, at the time of application, at least one policy covering home health care that satisfies 211 CMR 65.05(2)(c). *211 CMR 65.06(3)(a) [Note: A carrier may satisfy this requirement through the offer of an affiliated/ nonaffiliated carrier's product(s), as long as the arrangement for the offer of the other carrier's product is subject to a written contract filed with and approved by the commissioner. 211 CMR 65.06(3)(b)]*

___ Long-Term Care Insurance Benefits Qualifying the Insured for Exemptions from Certain Massachusetts MassHealth (Medicaid) Provisions:

___ A carrier must make available, at the time of application, at least one policy that satisfies the requirements of 130 CMR 515.014. *211 CMR 65.06(4)(a) [Note: A carrier may satisfy this requirement through the offer of an affiliated or nonaffiliated carrier's product(s), as long as the arrangement for the offer of the other carrier's product is subject to a written contract filed with and approved by the commissioner. 211 CMR 65.06(4)(b)]*

Limitations and Exclusions

Does the policy limit coverage for pre-existing conditions?

__ yes ___ no

If yes:

___ Pre-existing condition limitations must be identified on the front of the policy and the outline of coverage. *211 CMR 65.05(3)(a)1.*

___ Pre-existing condition limitations may not apply for more than a six-month period from the effective date of the policy. *211 CMR 65.05(3)(a)2.*

___ The policy must include a provision that if the insurer denies liability and refuses to make payment on the basis of a pre-existing condition, the insurer shall transmit to the insured together with the notice of denial of liability documented evidence of specific instances of actual treatment or observation of such pre-existing condition, illness or injury in all cases except those of a confidential nature. *M.G.L. c. 175, § 108 2.(a)(2A)*

___ No policy may exclude otherwise eligible persons from policy benefits due to the presence or history of mental or nervous conditions, Alzheimer's disease, alcoholism, or other chemical dependency. *211 CMR 65.05(3)(b)*

___ No individual policy may exclude otherwise eligible policy benefits because those benefits are also payable by a non-Medicare government agency or because the covered services are being received in a governmental facility. *211 CMR 65.05(3)(c)*

___ Individual policies may include other limitations or conditions subject to the approval of the commissioner, provided that they are clearly identified in a separate section of the policy. Such limitations may include, but are not limited to, illnesses, treatments or conditions arising out of the following circumstances:

1. war or act of war (whether declared or undeclared);
2. participation in a felony, riot or insurrection;
3. service in the armed forces or units auxiliary thereto;
4. attempted suicide or intentionally self-inflicted injury;
5. services provided for alcohol or drug detoxification;
6. aviation (this exclusion applies only to non-fare paying passengers);
7. services for which benefits are payable under Medicare, any state or federal workers' compensation program, employer's liability or occupational disease law, or any motor vehicle no-fault law;
8. services provided by members of the insured's immediate family; or
9. services for which no amount is normally charged in the absence of insurance. *211 CMR 65.05(3)(d)*

Uniform Provisions - Compliance with M.G.L. c. 175 § 108, 3.(a)

Under section 3.(a) of section 108, each policy must contain the following provisions in the words in which they appear; provided, however, that the insurer may substitute for one or more of such provisions corresponding provisions of different wording which are in each instance not less favorable in any respect to the insured. The provisions must be preceded by an appropriate caption at the beginning of each item or group of items.

___ **Entire Contract; Changes**

This policy, including endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. *M.G.L. c. 175, § 108, 3.(a)(1)*

___ **Time Limit on Certain Defenses**

After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such two-year period OR

Incontestable

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. *M.G.L. c. 175, § 108, 3.(a)(2)*

___ **Grace Period**

A grace period of [insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies] days will be granted for the payment of each premium falling due after the first premium during which grace period the policy shall continue in force. *M.G.L. c. 175, § 108, 3.(a)(3)*

___ **Reinstatement**

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as many be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or, in the case of a policy issued after age 44, for at least five years from its date of issue.) *M.G.L. c. 175, § 108, 3.(a)(4)*

___ **Notice of Claim**

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at [insert the location of such office as the insurer may designate for the purpose] or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. *M.G.L. c. 175, § 108, 3.(a)(5)*

___ **Claim Forms**

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. *M.G.L. c. 175, § 108, 3.(a)(6)*

___ **Proof of Loss**

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. *M.G.L. c. 175, § 108, 3.(a)(7)*

___ **Time of Payment of Claims**

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid [insert period for payment which must not be less frequently than monthly] and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. *M.G.L. c. 175, § 108, 3.(a)(8)*

___ **Payment of Claims**

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to such estate. All other indemnities will be payable to the insured.

The following two paragraphs, or either of them, may be added to this provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding [insert an amount which shall not exceed $1,000], to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person. *M.G.L. c. 175, § 108, 3.(a)(9)*

___ **Physical examinations**

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder. *M.G.L. c. 175, § 108, 3.(a)(10)*

___ **Legal actions**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of such loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. *M.G.L. c. 175, § 108, 3.(a)(11)*

___ **Change of beneficiary**

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy. *M.G.L. c. 175, § 108, 3.(a)(12)*

Optional Provisions - Compliance with M.G.L. c. 175 § 108, 3.(b)

Section 3.(b) of section 108 provides mandatory language for policies that include these provisions: *i.e.,* policies do not have to contain these provisions, but if they do, they must be in substantially similar language ("which [is] in each instance not less favorable in any respect to the insured or the beneficiary"). The provisions must be preceded by an appropriate caption at the beginning of each item or group of items.

___ **Misstatement of Age**

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. *M.G.L. c. 175, §108 3.(b)(2)*

___ **Other Insurance in This Insurer**

If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for [insert type of coverage or coverages] in excess of [insert maximum limit of indemnity or indemnities] the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

OR

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies. *M.G.L. c. 175, §108 3.(b)(3)*

___ **Insurance with Other Insurers**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the above policy provision is included in a policy which also contains the next following policy provisions there shall be added to the caption the phrase -- EXPENSE INCURRED BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities or this or any other state of the United States or any province of Canada, and by hospital or medical services organizations, and to any other coverage the inclusions of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying this policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute including any workmen's compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insured has had notice. In applying said policy provision no third party liability coverage shall be included as other valid coverage. M.G.L. c. 175, §108 3.(b)(4)

___ **Insurance with Other Insurers**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under the policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

If this policy provision is included in a policy which also contains the above policy provision there shall be added to the caption of this provision the phrase - OTHER BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law of by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying this policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute including any workmen's compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying this policy provision no third party liability coverage shall be included as other valid coverage. *M.G.L. c. 175, §108 3.(b)(5)*

___ **Unpaid Premium**

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. *M.G.L. c. 175, §108 3.(b)(7)*

___ **Conformity with State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. *M.G.L. c. 175, §108 3.(b)(9)*

___ **Illegal Occupation**

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. *M.G.L. c. 175, §108 3.(b)(10)*

Special Disclosure Forms

___ If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the actual policy terms must accompany the policy when it is delivered and must contain a statement substantially similar to the following: "NOTICE: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested, but it differs in the following respects: [list]." *211 CMR 65.09(3)(a) [Note: this would not apply to guaranteed issue policies.]*

___ If the carrier uses a worksheet or other marketing material to examine a potential applicant's financial situation, or uses any other marketing material that purport to provide guidance as to whether the applicant is suitable for long-term care insurance and subsequently notifies the applicant that the carrier finds the applicant to be suitable for long-term care insurance, the carrier shall provide the following disclosure notice:

"Although [the carrier] may have determined that you meet [its] internal standards of suitability, there are other considerations that might influence your decision about whether this product is appropriate for you. [The company] uses the following standards to determine suitability for its long-term care insurance policies:

[list]

Please note that you should not rely upon this statement alone in making this purchase. You may want to contact a financial advisor for additional information." *211 CMR 65.09(4)(b)*

Policy Illustration Form

___ The policy illustration form must be substantially similar to the following: *211 CMR 65.09(3)(b)*

[INSURANCE COMPANY NAME AND ADDRESS]
LONG-TERM CARE INSURANCE POLICY ILLUSTRATION FORM

[Note: Sections I-VIII must be on the front of the Policy Illustration Form and the text following must be on the reverse side of the Policy Illustration Form. Text on the reverse page will provide detail regarding any of the footnoted sections.]

I. FEDERAL TAX/STATE MASSHEALTH (MEDICAID) EXEMPTIONS

This Individual/Group Policy is Intended to:	Yes/No
1. Qualify for **Federal Income Tax** Deductions/Exemptions under Federal Law*	
2. Qualify for **MassHealth (Medicaid)** Exemptions under Massachusetts Law*	

***These laws are subject to change at any time.** These exemptions might not apply to this policy at a future date. Read *Your Options for Financing Long-Term Care: A Massachusetts Guide* for more information.

II. THIS POLICY COVERS THE FOLLOWING LONG-TERM CARE SERVICES

Type of Service	Daily Benefit[1]	Max Benefit ($/Days)[1]	Type of Service	Daily Benefit[1]	Max Benefit ($/Days)[1]
1. Nursing Home			5. Home Care		
2. Assisted Living			6. Adult Day Care		
3. Home Health Care			7. Respite Care		
4. Personal Care			8. Other		

III. BENEFIT LIMITS[2]

$_____ per day/month/year for _____ days/months/years **OR** $_____per lifetime

IV. BENEFITS BEGIN AFTER:

____ Days **OR** $ Deductible

V. EXCLUSIONS AND LIMITATIONS

Type	Yes/No[3]
PREEXISTING CONDITIONS	
OTHER:	

VI. TO BE ELIGIBILE FOR BENEFITS

[Drafting Note: In Section VI, carriers must include all the following text and cross out terms that do not apply in the policy for which the proposal is being developed. For example, this section must include both the terms "hands-on help" and "standby help" and the carrier shall cross out whichever does not apply.]

You must need supervision due to a cognitive impairment OR
You must need **hands-on help/standby help** with ___ of the following Activities of Daily Living: eating, transferring, bathing, dressing, toileting, continence due to a loss of physical capacity or severe cognitive impairment.

VII. OTHER BENEFITS

Yes/No	Type	Terms	Premium
	Inflation Protection		$
	Nonforfeiture Benefit		$
	Other		$

VIII. ANNUAL PREMIUM

Terms and Conditions[4]	Total
	$

IMPORTANT: This is a brief summary of proposed coverage. It is not a policy. If you choose to purchase a policy, please read and review your policy carefully to verify that the coverage you have purchased is the coverage you intended to purchase.

[1,2,3,4] See reverse side for more information

[Note: Page break is at this point.]

ADDITIONAL INFORMATION

[1] These benefit amounts usually are not cumulative. For example, if your policy provides a total of 730 days of coverage and you use 100 days to pay for home health care services, you will have 630 days of coverage left to apply to other services such as nursing home care.

Further information about the benefits covered by this policy:

[To be completed by carrier.]

[2] Long-term care insurance usually does not cover the full cost of long-term care services. According to the most recent *Your Options for Financing Long-Term Care: A Massachusetts Guide*, the **average cost** of private nursing home care in Massachusetts was $_____ per day and the **average stay in a nursing home lasted** ____days. The average cost of home health care services in Massachusetts was $ _____ per day.

Inflation is likely to have increased these average costs by the time you need long-term care services. Inflation protection coverage will help protect the value of your benefits:

[To be completed by carrier. INFLATION PROTECTION ILLUSTRATION demonstrating graphically how inflation and inflation protection option could affect policy benefits over 20-year period. If necessary, a separate page may be attached to the Policy Illustration Form that includes an illustration of the policy's inflation protection.

[3] Further information about the **exclusions or limitations** contained in this policy:

[To be completed by carrier.]

[4] **Level premiums** are designed to stay the same for the life of the policy, although they can be changed for an entire class of policyholders. **Guaranteed premiums** never can be increased. Some premiums are subject to **discounts** (for example, spousal discounts or a first-year-only discount).

Prepared For: [Name] **Date:**
Agent: [Name, Address, Phone]

Outline of Coverage

___ The outline of coverage must be a document separate from the policy. *211 CMR 65.09(3)(c)*
___ The outline of coverage must be substantially similar to the one that follows; however, text that is capitalized or underlined may be emphasized by other equivalent means. *211 CMR 65.09(3)(c)*

[CARRIER NAME]
[ADDRESS - CITY & STATE],[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number:

___ [The following three paragraphs must be included in substantially similar language at the top of the policy.]

FEDERAL INCOME TAX EXEMPTIONS: This policy (**IS)(IS NOT**) intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy **(IS)(IS NOT)** intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read *Your Options for Financing Long-Term Care: A Massachusetts Guide* for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

___ **1**. This policy is [an individual policy of insurance/a group policy which was issued in (indicate jurisdiction in which group policy was issued)]. THIS IS A LIMITED POLICY. This policy may not cover all the expenses associated with your long-term care needs.

[Except for policies or certificates that are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

___ **Caution:** The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue as of the date you signed the applications, the carrier has the right to deny benefits or rescind your policy subject to the [Time Limit on Certain Defenses, Incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers were incorrect, contact the carrier at this address: [insert address]

___ **2. SUMMARY OF POLICY FEATURES**

This policy:

1. is not a Medicare Supplement policy.
2. [is guaranteed renewable/is noncancelable] for your lifetime.
3. [is/is not] subject to automatic premium increases as you get older.
4. [may be/is not] subject to across the board premium increases for all policyholders in your class.
5. [does/does not] offer an option to purchase inflation protection after the policy is issued without any medical underwriting.
6. [does/does not] offer an option to purchase nonforfeiture protection after the policy is issued without any medical underwriting.
7. [does/does not] contain special age limitations for purchase.

8. [does not cover services due to pre-existing conditions (existing health problems) for a period of __ months from policy issue][does not have a waiting period before pre-existing conditions (existing health problems) are covered].
9. [may have/has] an elimination period of __ days before benefits are payable by policy.
10. [offers a waiver of premium after __ days of __ benefits][does not offer a waiver of premium].

___ **3. PURPOSE OF OUTLINE OF COVERAGE.** An outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains actual contractual provisions. This means that your [policy/certificate] sets forth in detail the rights and obligations of both you and the carrier. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR [POLICY/CERTIFICATE] CAREFULLY!

___ **4. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) [For long-term care insurance policies or certificates describe one of the following permissible policy renewability provisions:
(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS [POLICY[/CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

OR

(1) Policies and certificates that are noncancelable must contain the following statement:] RENEWABILITY: THIS [POLICY/CERTIFICATE] IS NONCANCELABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own without your agreement, and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Carrier Name] may increase your premium at that time for those additional benefits.

OR

(1) Policies and certificates that are convertible from a group policy must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS CONVERTIBLE TO AN INDIVIDUAL POLICY.](For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy:]

(b) [Describe waiver of premium provisions or state such provisions are not in the policy.]
(c) [State whether or not the carrier has a right to change premium, and if the right exists, describe clearly and concisely each circumstance under which premium may change, including that it is subject to the commissioner's approval.]

___ **5. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED**.
(a) [Provide a brief description of the right to return—the policy's "free look" provision, which must be a minimum of ten days from the date of policy delivery.]
(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

___ **6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the carrier.
(a) [For agents] Neither [insert carrier name] nor its agents represent Medicare, the federal government, or any state government.
(b) [For direct response] [insert carrier name] is not representing Medicare, the federal government or any state government.

___ **7. LONG-TERM CARE COVERAGE**. Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided

in a setting other than an acute care unit of a hospital, including, but not limited to care in a nursing home, other long-term care facility or program or in the home.

[Except for policies or certificates which have unlimited daily benefits and no coinsurance cost-sharing features, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

___ This [policy/certificate] provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements.

___ **8. BENEFITS PROVIDED BY THIS [POLICY/CERTIFICATE].**
(a) [Covered services, deductible(s), waiting periods, elimination periods and maximums.]
(b) [Institutional benefits, by skill level.]
(c) [Non-institutional benefits, by skill level.]

___ [A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must include an explanation of such terms in this section of the outline of coverage.]

___ [Any benefit screening must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

___ **9. LIMITATIONS AND EXCLUSIONS**
[Describe:
(a) Pre-existing conditions
(b) Non-eligible facilities/provider
(c) Non-eligible levels of care (*e.g.* unlicensed providers, care by a family member, etc.)
(d) Exclusions/exceptions
(e) Limitations]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

___ THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

___ **10. RELATIONSHIP OF COST OF CARE AND BENEFITS**. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
(a) That the benefit level will not increase over time;
(b) Any automatic benefit adjustment provisions;
(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by specified amount or percentage;
(d) If there is not a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

___ [Carriers must include the following information in or with the outline of coverage:
(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with the benefit levels of a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a 20-year period.
(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. A carrier may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.]
(3) Whether or not the benefit was chosen by the policyholder.]

___ **11. NONFORFEITURE BENEFITS**. As an accident and sickness policy, this policy does not have a cash value associated with life insurance products. This policy does offer [for an additional charge (if applicable)] a

nonforfeiture benefit that will continue until exhausted even if the policy lapses due to nonpayment of policy premiums. The following represents an example of how this benefit would apply to your policy: [As applicable, indicate the following:

___ [Carriers must include the following information in or with the outline of coverage:
(1) A description of the benefits that would accrue at different periods of policy lapse
(2) Whether or not the benefit was chosen by the policyholder.]

___ 12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

[State that the policy provides coverage for a person clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured.]

___ 13. PREMIUM

[(a) State the total annual premium for the policy;
(b) If the premium varies with an applicant's choice of benefit options, indicate the portion of annual premium that corresponds to each benefit option; OR
(c) Refer individual to schedule page of the policy. For reference during the presentation, individual may be referred to policy illustration form for premium.]

___ **COMPLAINTS**. If you have a complaint, call us at ( ) ____ or your agent. If you are not satisfied, you may call or write the Massachusetts Division of Insurance.

Application Form

Application form must be in no less than 12 point type and must meet the standards of M.G.L. c. 175, §2B. *See above section on §2B and verify that the application also meets all standards.*

Is the application for a guaranteed issue policy? __ yes___ no

If no:

___ All applications and enrollment forms shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant. *211 CMR 65.11(1)*

___The following language must appear conspicuously near the applicant's signature block on an application:

"Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your policy." *211 CMR 65.11(3)(a)*

___ If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, then it must also ask the applicant to list the medication that has been prescribed and the reason that the medication was prescribed. *211 CMR 65.11(2)*

___ Application forms must ask whether the insurance is being applied for to replace any other policy currently in force. *211 CMR 42.08(1) [Note: A supplementary application or other form to be signed by the applicant containing such a question may be used.]*

___ The application form must request the applicant to designate at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium, and must require that the applicant who wishes to waive this right do in writing. *211 CMR 65.10(1) [Note: The carrier may use a separate form for this designation. Make sure that there is a separate signature and date required for the waiver, whether it is on the application or a separate form.]*

___ The application form must require the applicant to specifically reject the inflation adjustment benefit if he/she chooses not to include this benefit in the policy. *211 CMR 65.06(1)(c)*

___ The application form must require the applicant to specifically reject the nonforfeiture benefit if he/she chooses not to include this benefit in the policy. *211 CMR 65.06(2)(c)*

___ Application forms must ask whether the insurance is being applied for to replace any other policy currently in force. *211 CMR 42.08(1) [Note: A supplementary application or other form to be signed by the applicant containing such a question may be used.]*

Confidentiality of Information

Application form must conform to requirements of *M.G.L. c. 175I*:

___ *§ 4*: A notice of information practices must be provided to all applicants no later than at the time the application for insurance is made. The notice must be in writing and must contain **EITHER**:

___whether personal information may be collected from persons other than the individual proposed for coverage; *M.G.L. c. 175I § 4(b)(1)*
___the type of personal information that may be collected and the type of source and investigative technique that may be used to collect such information; *M.G.L. c. 175I § 4(b)(2)*
___the type of disclosure permitted by chapter 175I and the circumstances under which such disclosure may be made without prior authorization: provided, however, that only such circumstances need be described which occur with such frequency as to indicate a general business practice; *M.G.L. c. 175I § 4(b)(3)*
___a description of the rights established under sections eight, nine and ten and the manner in which such rights may be exercised: *M.G.L. c. 175I § 4(b)(4)*
___ *§ 8* describes the right of an individual to obtain any personal information collected or maintained by the insurer upon written request, including any persons to whom the insurer has disclosed the information, and procedures by which such information may be corrected, amended, or deleted.
___ *§ 9* describes the right of an individual to have factual errors corrected and any misrepresentation or misleading information amended or deleted upon written request.
___ *§ 10* describes the right of an individual to receive the specific reason for an adverse underwriting decision in writing.
___that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons. *M.G.L. c. 175I § 4(b)(5)*

OR:

___ an abbreviated notice may be used that informs the applicant that:
___ personal information may be collected from a person other than the individual proposed for coverage; *§ 4(c)(1)*
___ such information as well as other personal or privileged information subsequently collected by the insurance institution or insurance representative may in certain circumstances be disclosed to a third party without authorization; *M.G.L. c. 175I § 4(c)(2)*
___ a right of access and correction exists with respect to all personal information collected; *§ 4(c)(3)*
___ the more detailed notices described above will be furnished to the applicant upon request. *§ (4)(c)(4) AND:*

___ Disclosure authorization form must meet requirements of *M.G.L. c. 175I § 6*:
___ 1. is written in plain language
___ 2. is dated
___ 3. specifies the types of persons authorized to disclose information about the individual
___ 4. specifies the nature of the information to be disclosed
___ 5. names the insurance company and identifies by generic reference the person to whom the applicant is authorizing information to be disclosed.
___ 6. specifies the purposes for which the information is collected.
___ 7. specifies that the authorization shall be valid for no longer than thirty months from the time it is signed
___ 8. advises the applicant that s/he is entitled to receive a copy of the authorization form.

Replacement Notice

___ A replacement notice, to be supplied to the applicant who indicates that the sale would involve replacement of another policy, must be submitted for review.

___ The replacement notice must be substantially the same as the following: *(211 CMR 42.99)*

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by ___ Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above "Notice to Applicant" was delivered to me on (date).

_____ Applicant